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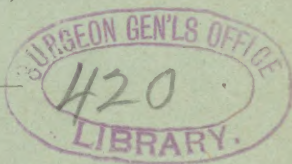
RECENT EXPERIENCE IN ABDOMINAL
SURGERY.

SIXTEEN CONSECUTIVE CASES.

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In calling attention to my experience in abdominal surgery, embraced within the period from March 13th, 1890, to February 28th, 1891, less than one year, I do not propose to go into the details of all the cases, but briefly mention such as seem worthy of comment. My cases number sixteen. Twelve of these recovered and four died. Twelve of my operations were done in the Clarkson Memorial hospital, with ten recoveries. One was done in the Immanuel hospital, which recovered; and three were done in private dwellings with one recovery. All of the four deaths were from lesions of the intestines—two absolutely necessarily fatal from the lesions found, and the condition of the patients at the time of operation. The twelve successful cases were, with two exceptions, pathological conditions of the ovaries or of the ovaries and tubes. To tabulate:

*Read before the Medical Society of the Missouri Valley, March 26, 1891.

Adhesions to the ovary.....	1
Ovarian tumors.....	4
Encysted dropsy.....	1
Pyosalpinx	2
Chronic ovaritis with salpingitis.....	3
Appendicitis.....	2
Intestinal obstruction.....	1
Sarcoma of the colon.....	1
Umbilical hernia (strangulated).....	1

I wish to select for my remarks, five out of my twelve recoveries, and also the four fatal cases. The others were of such character, difficult or easy, as many of you have frequently had in your practice.

CASE II.—Mrs. S. aged 28 years had been an invalid for ten years, suffering with a long chain of symptoms referable to the uterus and adnexa. Among the chief of these were pelvic pain and too frequent profuse menstruation. She had had a laceration of the cervix repaired, the uterus curetted, worn pessaries and the changes in local and internal treatment had been wrung dry, and I had assisted in the wringing. The diagnosis as to the true local condition of the adnexa was not positive. On May 5th, (in the Clarkson Hospital) the abdomen was opened and after considerable difficulty the ovaries and distended tubes were freed from extensive adhesions and removed. The convalescence from the operation was uninteresting.

Menstruation has never returned but the old pain continued for many months, and it is only recently that it began to disappear and at present is nearly gone. If such operations were followed up with reports, on the *results as to cure*, it would doubtless be found that many patients were not benefitted by operation, or if at all, only after the lapse of considerable time. Personally such cases are known to me, and one of them was reported before a State Medical Society by a distinguished gynaecologist as a cure, when to-day the woman is a confirmed invalid, menstruating and suffering pain as of yore.

CASE IV.—Mrs. J., aged 50—Multilocular Ovarian Tumor—Operation September 8, Clarkson Hospital.

The adhesions were universal to intestines, stomach, liver and parietal peritoneum, and their separation required much time and rather rough handling. After ligation of the pedicle the abdomen was well irrigated with hot water to combat the shock and stop the oozing. A drainage tube was employed and removed on second day. There was a sharp attack of peritonitis which was controlled and recovery was rapid. Tumor weighed seventy pounds. This was the most difficult operation for the

removal of an ovarian tumor I have ever seen, and the recovery of the patient was a surprise to the physicians present at the operation.

CASE V.—Mrs. F., aged 35 years—Multilocular Ovarian Tumor.

The patient thought herself pregnant; felt foetal life, and as the tumor grew prepared for her accouchment, notifying her physician of the expected event. Some two months after this date, she called her physician to explain the cause of delay, when upon examination the uterus was found normal in size and an ovarian tumor present. Menstruation had been normal. Operation October 8, Clarkson Hospital. A large multilocular tumor was removed; adhesions were plentiful. Irrigation and drainage; the tube was removed in twenty-four hours. Recovery uninterrupted.

CASE VII.—Mrs. C., aged 24 years. Patient had been suffering with inflammation in the region of the vermiform appendix for two weeks. Temperature ranging from 100° to 102° F. For two or three days prior to my seeing the case, there had been an aggravation of all symptoms and believing that interference was called for, she was removed to the Clarkson Hospital the same evening (October 28th), on which I first saw

her, and the abdomen opened at 10 o'clock at night. Incision five inches in right linea semilunaris. Intestines were matted together and after gentle manipulation, a small collection of pus was found and removed. The vermiform appendix could not be recognized. The upper half of the incision was closed, the peritoneum being sutured separately with cat-gut, and the region of the abscess and lower half of incision left open and packed with iodoform gauze. Recovery uninterrupted.

CASE XIII.—Mrs. G., aged 24. This woman was first seen by me during the fall of 1889, suffering with what seemed to be nephritic colic; the symptoms were apparently typical. She was seen again December 15, '90, and found practically bed-ridden from pain along the course of the right ureter extending down into the pelvis. On examination, a tumor the size of the fist was found on the right side of the uterus and intimately connected with it. The tumor was exquisitely sensitive; there was likewise a much smaller growth on the left side. Menstruation normal. The attacks were paroxysmal. When the woman attempted to stand the body was bent over on to the pelvis. It was noticed that pressure over McBurney's point

caused considerable flinching. I decided to open the abdomen and investigate. The growths were found to be sessile sub-peritoneal fibroids; the right ovary was adherent low down behind the large fibroid with strong adhesions to the omentum and small intestines binding it tightly against the growth; these were freed, the omentum being shortened by amputation. On account of its depth and position I could not remove the ovary. The right kidney was palpated and found normal and the vermitiform appendix carefully examined and also found normal. Convalescence was satisfactory. I was recently informed that the patient was free from pain and is attending to her duties as a housekeeper.

CASE III—Mr.C., aged 54. I was telegraphed to go to a city one hundred miles distant to operate for strangulated hernia. On arrival, I found a man weighing 350 lbs., with a large umbilical hernia which had been incarcerated for three days. After spending twenty-four hours at personal manipulation, the patient had sent for medical aid, and the gentleman called tried taxis on two occasions under chloroform. The skin over the hernia was oedematous, mostly I thought as a result of the taxis. I declined to operate as there were no posi-

tive symptoms of strangulation, the man being free from pain and in excellent condition, saying he felt perfectly well. Temperature 99°, pulse 84. Ice was advised locally. Early next morning I was again summoned, and found an elevation of temperature and increased frequency of the pulse, tumor somewhat painful. I opened the sac and found an omental hernia, a small part of the omentum quite black and some other highly congested; this was amputated. There was also another hernial sac adherent to this one, having its exit from the abdomen just above it, the rings being separated by one-half inch of parietal wall. The coverings of these sacs were the same, the contents of the smaller being intestinal, and not strangulated. This form of double sac is much less common than that variety where there are two necks to the same sac, which results (Wood) "from the remains of the uracus and hypogastric arteries at the upper part of the superior false ligament of the bladder, traversing the interior of the sac to the navel cicatrix, with adhesions to the neck, and with a pouch on each side, one of which may contain omentum, and the other large or small intestines. The suspensory ligament of the liver has been seen to form a similar division of the sac." It was not easy to

reduce the omental hernia, so its ring was enlarged both downwards and upwards into the ring of the smaller hernia. The operation was completed by attempting a radical cure. The patient rallied well from the operation, but gradually sank, dying forty-eight hours later. The post mortem showed the intestines normal, omental stump congested, and a circle of inflamed parietal peritoneum three inches in diameter surrounding the sutured rings—Primary union. What killed this man? Those whose experience has given them a variety of subjects, know that it is in the obese that a prolonged operation is dangerous at best, and most frequently fatal. The attending physician counseled operation on my first visit—the result proved his judgment better than my own.

CASE XI—Mrs. C., aged 35 years, was first seen by me September 25, 1890. Her condition was hectic, symptoms referable to the pelvis. Examination revealed an apparently typical old-fashioned "pelvic cellulitis." I urged immediate operation as giving the only hope. Consent was finally obtained. Patient would not go into a hospital, so the operation was done at her home, October 3. On opening the abdomen, after breaking up a few adhesions, a

gangrenous stinking tumor was exposed and thought to be a tube, but on attempting its separation it broke down and a large new growth involving the meso-colon and three-fourths of the lumen of the large intestine had to be removed. There was no backing out, in the crumbling of the gangrenous mass the sigmoid flexure was widely opened. I therefore did Madelung's operation, removing some ten inches of the gut with its mesentery, and because of the tension had to establish the artificial anus at the upper angle of my incision. It was only owing to the cleverness of my assistants that I was able to get the patient into her bed alive. She rallied somewhat, but died on the third day. Post mortem not allowed. Growth proved to be a sarcoma.

CASE XIV.—Mrs. C. aged 36 was first seen by me about the last of November. There was a history of obstruction of the bowels commencing two months previously. The attack had been sudden and no efforts had availed for one month to produce an evacuation. At the end of that period several small, loose, thin movements took place and from that time to date there had been no movements, except on two or three occasions after the use of enemata, but these move-

ments had been very small. The classical symptoms of chronic intussusception, so well described by Treves, were marked. The intussusception could just be reached in the rectum, and the point through which the movements had taken place, recognized as a kind of dimple. The woman's condition was very bad. There was constant vomiting of a feculent character, and no nourishment could be retained. Three plans suggested themselves. 1. Lumbar Colotomy—2. Inguinal Colotomy—3. Abdominal Section for the purpose of, if possible, reducing the invagination, failing this, to establish an artificial anus. On December 7th, (Clarkson Hospital) I chose the third. Nothing could be done to overcome the obstruction, in fact, because of the distention of the large intestine above the intussusception it was most difficult to recognize the different parts of the colon. Neither the caecum, ascending or descending colon were where they usually belonged. A prolonged examination was out of question, so I closed my median incision and did a left inguinal colotomy (Littre's operation). The bowel was fastened in the incision but not opened. I did not want to open the bowel for four or five days, but the patient's condition was such, that at the end of forty-eight hours I

did so, the relief was wonderful. Late at night of the day on which I opened the bowel, while straining and having an enormous movement the woman was seized with intense pain, and when I saw her and could clear away the faeces sufficiently to make a careful examination the cause was evident—a suture at the upper angle of the incision had given way and allowed a leakage into the peritoneal cavity. I immediately closed the opening into the gut, and did what I could but the damage had been done, and death followed the next night. No post mortem could be obtained.

CASE XVI.—Mrs E. aged thirty-eight—was admitted into the Clarkson Hospital February 21st—she was unconscious, pupils widely dilated and did not respond to light. Copious loose involuntary evacuations from the bowels. Thighs flexed onto the the abdomen. Temperature 102° F.—pulse 110. The uterus was fixed and there was plainly some peritoneal inflammation. She had been sick one week, and under the care of physicians, who had, I understood, gotten the impression that the woman had taken opium in poisonous quantity, and it was quite evident that belladonna had been given her. Under symptomatic treatment she became conscious in two

days, and the temperature went down to 99°F., but frightful pain was complained of radiating all over the abdomen most acute over the uterus. Digital examination revealed a mass in Douglas' pouch on the left of the uterus. I did not see the case for nearly two days—when I did her condition was generally bad, pain continuing, her cries keeping the whole house disturbed. Examination with consultants found the mass larger and extending to the right. Not much tympanites. Diagnosis—pus in the pelvis from most likely a fallopian tube, possibly from a masked appendicitis. This opinion was given to those present before I opened the abdomen which I did February 28th. There was a general peritonitis. An abscess around the region of the location of the appendix containing about two ounces of putrid pus was evacuated and another, distinctly separate from this, was opened deep down behind the uterus. This contained quite a large amount of the same kind of pus. Leakage had I think, already taken place, before operation. Most careful and copious irrigation was used, and in addition to a tube, iodoform gauze was packed into the pelvis and the positions of the abscesses. It was evident to all when the peritoneum was opened that

there was no hope, still a careful attempt to save life was made. Death in thirty hours. The post mortem examination showed the tubes not involved, and a gangrenous appendix, mostly destroyed. I do not think it was possible to recognize the true lesion, under all the circumstances, early enough to have had surgery do any good. The physical signs were of pyosalpinx.

REMARKS.—I use no chemicals in irrigating, simply hot, boiled water, and gauze, either iodoform or sterilized for sponging. Drainage whenever I have irrigated. Operating as rapidly as consistent with careful work, and although not a particularly rapid operator, I have succeeded in removing successfully both of the ovaries and their tubes in twenty minutes from the commencement of my incision until it was closed by the tying of the last suture. Silk is used for tying pedicles, cat-gut for blood vessels. These few cases are given to illustrate abdominal surgery happening in the practice of a general surgeon, other than which I do not claim to be, although, according to my best information, the total number of my abdominal sections to date is about double that of any other operator in Nebraska, yet they are

so few when compared with those of our well-known specialists in the East that they are scarcely worth consideration. Still, from my limited experience and a liberal clinical observation and acquaintance with the published work of others, the standpoint from which most of us must view these cases, the following rules seem common sense:

1. Never operate upon a practically moribund patient, whose disease is chronic.

2. The same rule applies to all acute diseases or injury except where hemorrhage is the depressing or suspectedly depressing cause.

3. Never hesitate to operate upon otherwise hopeless cases, if experience has proven success to have followed interference, even if in only a very small percentage.

4. Use all the principles of modern anti-septic surgery *before* opening the abdomen, those of aseptic surgery *afterwards*.

5. Drain only after irrigation, evacuate the tube frequently and remove it early.

6. No nourishment by the mouth for twenty-four hours, giving hot water in small quantities to allay thirst.

7. Peritonitis should be treated by large doses of calomel and copious turpentine enemas. In intestinal lesions, splinting the bowel by opium may be the proper practice.

8. Use whatever technique is simplest and easiest, thereby diminishing shock and lessening the dangers of an always possible infection.

